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ABSTRACT

This paper addresses the problem of school phobia, one of the most common childhood anxiety disorders. It presents four case studies of preadolescent school phobia involving two girls and two boys in grades four through seven. Several features of effective strategies for the assessment and treatment of school phobia which have emerged from the four case studies are discussed, including: (1) the importance of the family-child interaction; (2) the possibility that strictly behavioral observations may lead to inaccurate conclusions about the nature or extent of the phobia; and (3) the importance of incorporating self-management strategies into the treatment. A protocal is presented, based on the case studies and the strategies listed, which suggests a family-based consultation system rather than a child-based intervention. Assessment procedures discussed include the use of parent and child interviews, rating scales, anxiety ratings, and behavioral records; treatment procedures focus on goal setting, reinforcement, self-monitoring, relaxation training, support for the child, and parent education. It is noted that use of this protocol in the four case studies resulted in remission of the symptom of school refusal in every case. The protocol outlined in this report should address the distortions seen in family interactions and provide both child and family with effective ways of coping with the symptom of school refusal. (NB)

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A Protocol for the Assessment and Treatment of School Phobia

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A Protocol for the Assessment and Treatment of School Phobia

For purposes of this paper, school phobia is used to refer to a syndrome where the child refuses to attend school, reports periodic episodes of serious panic while at school, and the symptoms are sufficiently persistent to disrupt school progress.

In factor analytic studies, phobias are typically grouped with the anxiety/withdrawal disorders (Quay, 1979). School phobias are among the more common childhood anxiety disorders. Kennedy (1965) estimated the incidence of school phobic reactions at 17 per 1000 children. Rutter, Tizard, & Whitmore (1970) reported a rate of 7 serious fear reactions per thousand children. Fears are developmentally normal in children, and tend to decrease in number with age (Granziano, DeGiovanni, & Garcia, 1979). In particular, fear of separating from parents is developmentally normal in young children; typically the school refusal in five and six-year-olds resolves itself once the parents and child become familiar with the routine of school attendance. Several authors have noted a second increase in fears in children around the age of eleven years (Chazan, 1962; MacFarlane, Allen, & Hozik, 1954). A discussion of school phobia in the third revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III; American Psychiatric Association, 1980) asserts that the more severe form of school refusal usually begins between eleven and

twelve. At this age school refusal is not easily explained by a lack of familiarity with school, as the children typically have a history of successful school attendance.

Disagreements exist over whether the school is, in fact, the feared object of a school phobic child. School phobia is discussed in DSM-III as a form of separation anxiety disorder; in many cases the symptom of school refusal is noted when what the child actually fears is being separated from primary caretakers. As such, DSM-III provides diagnostic criteria only for separation anxiety. The first and primary diagnostic criterion given is excessive anxiety concerning separation from those to whom the child is attached. Despite this emphasis on separation anxiety, footnotes in DSM-III clarify that a fear of separation does not invariably account for the symptom of school refusal. Used in the strictest sense, school phobia is a term used to describe those situations where a child shows fear to the school itself.

Theories proposed to explain the onset of phobic reactions have not been altogether satisfactory. Mowrer (1960) proposed an explanation for phobias which drew on both classical and operant conditioning theory. He suggested that a phobia was a classically conditioned response to some aversive incident; avoiding the feared object was then reinforced as the child's anxiety lessened in its absence. Objections to this theory have been raised because the phobic reactions do not extinguish as quickly and easily as the theory would

predict (Marks, 1969) and because the avoidance response can sometimes occur in the absence of any fear response (Carr, 1979). An alternative learning theory of phobias relies on modeling and operant conditioning theory (Bandura and Rosenthal, 1966) In this case it is assumed that the child observes family members avoiding certain situations, assumes those same avoidance behaviors, and is reinforced for the avoidance. The possibility that some children are physiologically anxiety prone has been suggested and must also be considered (See Morris & Kratochwill, 1983b, for a discussion.)

Because fears are developmentally normal in children, they are not typically singled out for clinical treatment unless they are out of proportion to the situation, cannot be explained away by other childhood experiences, are beyond the voluntary control of the child (Marks,1969), are unusually persistent, and are maladaptive (Miller et al., 1974; Morris & Kratochwill, 1983a). Thus, it is not surprising to find that children are referred more frequently to mental health professionals for school phobia than for other phobic reactions. Not attending school has a debilitating impact on a child's ability to accomplish the essential childhood task of schooling.

In discussing the treatment of children's fears and phobias, Barrios, Hartmann, & Shigetomi (1981) prescribe the use of self-control procedures such as self-monitoring,

self-reinforcement, self-instruction, thought stopping, applied relaxation, and problem solving. They describe this as a coping skills approach to provide strategies whereby the child manages his or her own anxiety responses. A variation of this strategy was employed in the cases discussed here, with both parents and children being taught coping strategies to manage the school refusal.

The protocol presented here emerged from the assessment and treatment of four cases of pre-adolescent school phobia seen at a University clinic. The protocol provides a plan for services which we follow and which emerged from single case studies. Data demonstrates the remission of the symptom of school refusal in every case, but will not show a systematic evaluation of the generalizability of the protocol, or of relative importance of its component parts.

THE CHILDREN

The four children seen include two girls and two boys, students in the fourth through seventh grades, enrolled in a rural parochial school. (See Table 1 for descriptive information.) Their ages ranged from 10 years - 5 months to 13 years - 0 months, with an average age of 11 years - 9 months. Children came to the clinic with their parents and were seen for an average of 14 appointments, spanning an average of three months. One child, Jeff, was seen on two occasions. One child, Ryan, is still being seen. The presenting problem for each child was school refusal and severe, observable distress

at the point of going to school. In three of the four cases, the onset of school refusal was set at the resumption of school in the first week of January. There were variations in the number of days children had been allowed by their parents to stay home. One child had not attended school at all for the three weeks since the Christmastime break. The other three hadn't been allowed by their parents to stay home for more than three days but parents were struggling with the children's obvious distress at school attendance. The children were protesting against school attendance, reported panic attacks in school, and frequently called parents during the day to request permission to go home. One child, Jeff, had chased his father's van for three blocks after being dropped off at the school door. All families had sought explanations for the children's fear of school; it was frequently difficult to decide which of these explanaions was most accurate at the time the child was first seen. Brief descriptions of the four children follow:

Donna. Donna, age eleven, refused to return to school after her sixth grade Christmastime break; her complaints of stomach aches and general malaise had convinced parents that she was physically ill and they spent several weeks taking her to medical specialists. Referral to the clinic was made as an alternative to homebound instruction. Absenses prior to that time were minimal, and she was described by teachers and parents as a very intelligent, successful

student. Socially, she was noted to be well adjusted but somewhat more reserved than her twin sister. Stressors in the family included the imminent death of a grandparent, an older brother's recent move away from home, an impending long term absence of her classroom teacher, concerns about her mother's drinking, and concerns about parental arguing. In addition to school phobia, Donna showed a reluctance to enter stores, restaurants, and her church. She began to avoid large family gatherings and outings with friends. Because her school refusal was more established, procedures to move her back into regular school attendance were more gradual. For the first several weeks Donna made slow but steady progress. Her slow progress back to school was especially frustrating for her parents, and in response to their irritation, she began to throw temper tantrums and isolate herself in a basement bedroom. At that point treatment was interrupted while the family was referred for family therapy. The program to move Donna back into school resumed after seven weeks. Once school attendance resumed normalcy, the family used the procedures they had learned to help Donna successfully overcome her reluctance to shop, eat out, go to Sunday services, and attend a family wedding. Followup one year later showed continued satisfactory school attendance.

Alice. Alice, age twelve, had been struggling with school refusal since the beginning of the school year. Being in the seventh grade, she had transferred that fall to the

county's middle school in a nearby town. There she had regular attendance but frequently panicked during the school day and begged to be sent home. In response to her discomfort, parents allowed her to transfer in October to the local K - 8 parochial school. The school refusal symptoms disappeared temporarily, but resumed after the Christmastime break. Because Alice's family was very reluctant to allow her to stay home from school, she missed very few days. Because of her frequent bouts of panic, she called home frequently and parents were beginning to consider requesting homebound instruction. Stressors included the recent move out-of-state of her best friend, the emerging alcoholism of her older brother who had subsequently been asked to leave the home, and the resumption of her mother's working outside the home. Alice and her family cooperated actively and enthusiastically with the treatment plan and she returned to regular school attendance immediately, and reported no further anxiety attacks within four weeks. Followup one year later showed no further school refusal.

Jeff. Jeff was first referred for school refusal in the spring of his fourth grade year. He complained to his parents that other students were unkind to him on the bus and at recess. Parents and teachers confirmed that Jeff tended to be awkward socially, but thought the school refusal was out of proportion to the complaints. Jeff's parents cooperated well with the treatment program suggested and he moved quite quickly back into full time school attendance; Jeff, however, was

reluctant to complete any recording tasks given to him. The issue of social skills was as yet unresolved when the school year ended. Eight weeks into the following fall, Jeff's school refusal recurred. At this point his protests against school attendance seemed more desperate and complaints about peers increased. Treatment procedures were reinstigated and in addition several observations of recess were conducted. Observation suggested that Jeff was on the fringes of the classroom peer group although he was not usually excluded from peer activities. Observers described his attempts to initiate interactions with other children as awkward, and noted that he was rarely complimented or helped by classmates. Parents received independent reports that Jeff was the victim of several cruel teasing incidents during times when no adults were present. In response they transferred Jeff to a new school; none of the school refusal symptoms have been noted in the first eight weeks at that school.

Ryan. Ryan is the only child currently in treatment for school phobia. A fourth grader, Ryan had shown severe distress upon returning to school after the Christmastime break. In addition to school refusal, Ryan had begun to ritualistically check with his father each morning to be sure that the house was secure before leaving for school. Ryan's parents had been divorced for several years, with his father having custody. Since the onset of school refusal, he had refused some visits to his mother who lived out of state.

Ryan's parents could identify no changes in the family routine that might relate to the onset of his school phobia.

ASSESSMENT PROCEDURES

Assessment strategies were intended to provide information necessary to confirm the diagnosis of school phobia, to provide information descriptive of the child and the nature of the phobia, to provide information for individualizing a treatment plan, and to provide base measures from which to evaluate treatment progress. The assessment procedures included an interview of the parents and school phobic child, completion by the child of the Louisville Fear Survey (Miller, Barrett, Hampe, & Noble, 1972) and the Revised Children's Manifest Anxiety Scale (Reynolds & Richmond, 1985; 1978), subjective ratings of anxiety using an individualized anxiety rating scale, and records of the child's school attendance behaviors. Some of these procedures were administered as part of the initial planning appointment, others were used as process assessment tools to monitor the progress of treatment while it was ongoing, and some were used as pre-/post- measures of treatment effectiveness. The following discussion of each measure includes a description of how and when it was implemented and a discussion of its rationale.

A parent and child interview. During the first meeting with the family, answers were sought which would provide a complete description of the school refusal behaviors.

Questions were planned to elicit a calendar of school attendance, a description of the antecedents and consequences of school refusal, a description of behaviors related to school refusal, a description of the family context, a description of the school situation, and descriptions of any other anxiety incidents or precipitating events. A summary of questions included in every interview are included in Table 2. Responses clarified the nature of the child's school refusal and related symptoms.

Rating Scales. Two rating scales were included in the assessment procedures: The Louisville Fear Survey (Miller et al., 1972) and the Revised Children's Manifest Anxiety Scale (Reynolds & Richmond, 1985; 1978). Both were completed by the child during the first appointment, and again at the end of treatment.

The Louisville Fear Survey (Miller et al., 1972) is a list of 81 possible fears a child might have. The child, or their parent, is asked to indicate whether the child has no fear, normal fear, or excessive fear of any of the listed items. Miller et al. (1972, 1974) used the checklist to evaluate the prevalence and factor structure of childhood fears included in the checklist, and the reliability or validity of the ratings has not been systematically evaluated (Morris & Kratochwill, 1983a). However, the listed fears can guide a comprehensive investigation of the child's reported comfort in a variety of situations that have caused discomfort in other

children. Table 3 summarizes both pre- and post-treatment responses of the four school phobic children to the Louisville. Children reported considerably more fears and more severe fears when they were first seen at the clinic. Parents described these child reports as accurate, noting that children showed fewer avoidance behaviors in several situations after the school refusal was resolved. In two of the three completed cases, it was deemed unnecessary to treat additional fears once the fear of school had subsided. Children's responses to the Louisville gave indiction of whether the fear of school was generalizing to or may have been generalized from other fearful situations. Second, responses to the fear survey indicated whether other fears might merit treatment in addition to the fear of school.

The Revised Children's Manifest Anxiety Scale (Reynolds & Richmond, 1985; 1978) is composed of 37 items describing signs of childhood anxiety. The child is asked to complete the scale by circling <u>yes</u> or <u>no</u> after reading each item. The scale is supported by over 100 published studies conducted on the original version (Reynolds & Richmond, 1985) and was renormed on a national sample of 4,792 children between the ages of 6 and 19 years (Reynolds & Paget, 1982). Given its respectable standardization and reliability, the RCMAS serves as a useful measure of the degree of a child's anxiety relative to other children of similar age. Table 4 shows the RCMAS scores for three of the four school phobia cases. At the time

of their first appointment, two children scored above the first standard deviation on the RCMAS indicating levels of anxiety higher than 84% of the population. In those two cases, results had fallen slightly and were below the clinically significant level after treatment. Ryan's RCMAS scores fell within the average range.

Anxiety ratings. In addition to the interview and rating scales, a subjective anxiety rating procedure was used in an attempt to quantify the child's perceived anxiety. The rating procedure was developed and explained to the child during the initial appointment, and used by the child to rate the anxiety felt during each step of a typical school day prior to treatment.

Each child was helped to construct an individualized anxiety scale, using the following procedure: a line divided into 7 numbered segments was shown to the child. Segments were labeled from 1 very calm to 7 very anxious. The child was asked to describe a time when they were as anxious as they had ever been, and that incident was written next to seven. In the same way, representative incidents were attached to the numbers 1, 6, 2, 4, 5, and 3 in that order. An example of one child's anxiety scale is included in Figure 1. This scale became the child's individualized anxiety scale. During the initial appointment, each child was asked to describe a typical school day in detail from the time they awoke in the morning until they arrived back home from school. The description was

recorded as a series of steps for normal school attendance. Then each child was helped to retrospectively rate each step of the day using their individualized anxiety scale. Figure 2 includes an example of a typical school day with the child's anxiety ratings. Table 5 summarizes the retrospecive anxety ratings of a typical school day for three of the four cases.

Information from the procedure served to identify those portions of the school day which were most problematical for the child. For example for Alice and Ryan, times when the child separated from parents were most problematical. In a Jeff's case, times when the child joined other children on the bus or during recess were most problematical. Alice and Ryan had not been allowed to stay home from school but reported very intense anxiety during the school day. Thus the treatment goal in these cases was to raise the child's comfort level during the school day. In these cases the anxiety rating procedure was adapted to serve as a process assessment of treatment effectiveness. Children were asked to carry with them a copy of their school day schedule. At each step during the day, they were to rate the level of anxiety they were feeling using their 7-point scale. A summary of the daily anxiety records kept by Alice is included in Table 6.

Behavioral records. In addition to these measures, regular records were kept of days the child didn't go to school, left school in the middle of the day, or stayed in school but felt very anxious.

TREATMENT PROCEDURES

In every case the ultimate goal for treatment was to return the child to consistent, comfortable, normal school attendance. In addition, secondary goals were relevant in each case. When first seen, children felt helpless and at the mercy of bouts of anxiety that they could not control. Treatment procedures were intended to reestablish their control over the anxious episodes and subsequent school attendance. When first seen, children would describe themselves as abnormal and incompetent. Treatment procedures were intended to reestablish the child's view of him or herself as competent and normal. Finally when first seen, children had begun to isolate themselves from family and/or friends. Treatment procedures were intended to prompt the child to reintegrate themselves into a social support network of parents and friends.

Treatment procedures varied to suit the individual need of each child. Moreover, experiences gained from earlier cases guided treatment plans for later cases. Procedures used included daily goalsetting, reinforcement, self monitoring, relaxation training, provision of a supportive relationship for the child, and parent education. Figure 3 shows the schedule of modal treatment procedures typically used in the four cases, including the order in which these were implemented and the typical duration. Figure 4 shows the progress of treatment over time for each of the four cases, with points at which each of the treatment procedures was initiated. The procedures and

their rationale are described below.

Goalsetting. Procedures were explained during the first appointment with each family to establish daily goals for the child's school attendance. Families were instructed to include both parents and the school phobic child in daily goalsetting decisions. Instructions in appropriate goalsetting were provided as follows: 1. Initially goals were set at the level of school attendance that the child had successfully demonstrated already. 2. Goals were raised in incremental steps. 3. After any unsuccessful day the goals were reduced slightly from those set the day before. Daily goals were reviewed with families during weekly clinic visits, and consultation concerning daily goalsetting was provided by phone during the week interval between clinic appointments.

For three of the four cases, the daily goals were raised to include full, daily school attendance by the end of the first week. Parents had been encouraged to return the children to regular school attendance when telephoning to make the first clinic appointment, and in these three cases this suggestion was sufficient for parents to be able to enforce a return to regular school attendance. Donna had not attended school since before the Christmastime break. Goals in her case consisted of gradual approximations to school attendance. Examples of Donna's steps are reported in Table 7. Other goals set for children included limiting the length of phone calls to parents, riding the bus, and resuming outings with friends.

Daily goals were recorded and achievements noted on a record sheet (Figure 5).

The process of goalsetting incorporated several strategies. First the goalsetting incorporated a shaping procedure in that daily goals were set to be successive approximations to the ultimate goal of consistent, comfortable school attendance. Second, the goalsetting incorporated a self-monitoring procedure in that the child kept records of daily goals and success in meeting these. Third, and most importantly, the goalsetting procedure modified child and family expectations for school attendance. Previously each family had defined 'ok' behavior as regular, comfortable school attendance. Times the child protested school attendance, or admitted to discomfort, became defined as failures. As a result children came under increasing pressure to attend school successfully at the very times when they were experiencing the most discomfort with school attendance. At a certain point parental disappointment with their child's behavior turned to anger, increasing child stress still further. When families successfully engaged in daily goalsetting, they redefined the child's approximations to school attendance as successes.

Reinforcement. From the first appointment, three children earned daily or weekly rewards by meeting a sufficient percentage of their daily goals. The percentage of goals needed to earn the weekly reward was set on a weekly basis. A $5.00 weekly limit was placed on the rewards, and families were

encouraged to substitute activities requiring parent time for purchased rewards. Examples of rewards used by families include a half-hour basketball game with dad, a pan of brownies baked by mom, a hamster and related equipment (earned over several successive weeks), a trip to the high school hockey game, and dinner out for dad and the phobic child. This reward system served several purposes in addition to the reinforcement they provided. First, importance was lent to the daily goals. Second, attention was focused on the success of children in reaching weekly goals. Finally, the interactive rewards increased time spent together by parents and children.

Self-monitoring. In two cases, children were actually attending school but were experiencing severe panic attacks before and during school. In addition to keeping records of their daily goals toward school attendance, these children were asked to self-monitor their level of anxiety throughout the day. An example of the self-monitoring procedures using the schedule of steps in a school day and the personalized anxiety rating scale have been explained above.

These records served to assess the child's progress towards comfortable school attendance. In addition they provided children with a language to use in discussing different levels of anxiety. Child reports suggest that like many self-monitoring procedures, the daily anxiety ratings were reactive. Children noted thinking during an anxious moment that it was difficult but was still only a '5', and they had handled

5's before.

Relaxation training. After the goalsetting, reward, and self-monitoring procedures had been initiated and families were trained in their implementation, three of the four children were given training in a progressive relaxation procedure. Relaxation instructions (Morris & Kratochwill, 1983b) were recorded on a cassette tape, and the child and psychologist reviewed the tape together during a clinic appointment. The child was given the cassette tape at the end of the session, and daily review of the tape was included as part of the daily goal. The relaxation procedure was discontinued with one child after he lost two tapes, and regularly protested the enforced practice.

The relaxation instructions provided the child with an effective coping strategy to use when an anxious moment occurred. Daily practice made it possible for children to remember the instructions at the necessary moment, even though the cassette was not readily available. One child reported reviewing the tape in her mind during a long car trip away from home; another child reported remembering the instructions during a teasing incident on the playground.

Support for the child. An important part of each clinic appointment was a private talking time between the child and the psychologist. The purpose of this was to provide an opportunity for the child to talk their experience with an adult who had no immediate investment in the child's return to

school. The psychologist would ask how the week had gone, solicit concerns the child chose to raise, and ask the child to report what they had been thinking about during anxious moments that occurred in the previous week.

The symptom of school refusal had, in every case, proved extremely disruptive to the family routine and family interactions. All four children were aware of the impact their panic had imposed on the family, and reacted to this in different ways. Three of the four children described feeling guilty about the havoc they had imposed on the family. Two felt betrayed by family members who didn't appear to understand the helplessness they were experiencing while in a panic. One child talked about running away to take the problem away from the family; another locked herself in a basement room when feeling alienated. All four children reported times when they didn't tell other family members how anxious they were feeling, pretending things were going better than they truly were. Other secrets children reported keeping from their families included ways one child was working to keep the older brother communicating with parents, concerns another child had about parental drinking, and a concern of one child that dreams of bad school experiences would forshadow a very difficult day at school. All four children reported times when they felt that the rest of the family suspected they were lying about how difficult it was to return to school. In effect, the symptom of school refusal appeared to be erecting barriers between the

school phobic child and the rest of the family. The talking time allowed the child to say out loud some of these 'forbidden' secrets, and often prompted the child to begin sharing these feelings with family members once more. If the child did not spontaneously begin sharing secrets, the psychologist would prompt them to do so.

Parent education. Parents and the school phobic child were give instruction in the nature and causes of children's phobias. The rationale behind procedures were explained as each was implemented. Responsibility for the implementation procedures was kept, as much as possible, with the family. Families began to report incidents where they had generalized the procedures to other phobic incidents, without the benefit of clinic consultation. By the end of treatment, each family was confident of their ability to recognize and cope with a similar phobic episode should it recur.

SUMMARY

Several features of effective strategies for the assessment and treatment of school phobia have emerged from the four case studies discussed here. First, the importance of the family/child interation is notable. In all cases, the symptom of school refusal placed serious stress on family/child communication. In some cases, the distortion of family/child interactions exacerbated the symptom of school refusal. There is potential for this to develope into a cyclical reaction, with the school refusal feeding into distorted family

interactions which in turn allow the symptom to worsen. In view of this cycle, theories that attribute school refusal to disturbed family relationships must be questioned unless the therapist has had an opportunity to observe those relationships independent of the symptom. Second, it is clear that strictly behavioral observations may lead to inaccurate conclusions about the nature or extent of the phobia. The configuration of fears and avoidance behaviors changed considerably once the symptom of school refusal was in remission. This does not necessarily imply that the school is always the true object of the phobia. Instead, the symptom of school refusal is sufficently disruptive to the child's daily routine to exaggerate the stress of the situation and to distort other behavioral symptoms the child may show. Finally, the importance of incorporating self-management strategies into the treatment are clear. Self-monitoring, relaxation, and goal-setting are strategies which give the child alternatives to school refusal.

Given these requirements, this protocol is suggesting family-based consultation system rather than a child-based intervention in order to address the distortions seen in family interactions and to provide both child and family with effective ways of coping with the symptom of school refusal.

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Table 1. Descriptive Case Data for Four School Phobic Children.

	Donna	Alice	Jeff	Ryan
Age	11-6	13-0	10-5, 11-0	12-1
Grade	6	7	4, 5	4
Sex	F	F	M	M
Interval Since Onset of School Refusal Symptoms	3 wks.	19 wks.	2 wks.	3 wks.
Number of Days Missed Since Onset	14	4	2	0
History of School Absences	Normal	Normal	22/year	Normal
Time of Year At Onset	After Christmas Break	After Christmas Break	Spring, Mid-Fall	After Christmas Break
Number Weeks Seen in Clinic	16	10	7, 8	Not Yet Complete
Recent Changes at Home/School	Grandfather very ill. Concerns w/ parental drinking, arguing.	Older brother Feuding w/ family; Mother return to work. Best friend moved away.	Mother returned to work. Difficulties w/ peer relations.	Routine visit to mother's home in nearby state.

Table 2: Summary of family interview

A calendar of school attendance. How many days had the child stayed home from school? Which days? How many days had the child left school before the day's end? Which days?

A description of the antecedents and consequences of school refusal. What did the child do during mornings that preceeded their staying home? Why did parents decide to let the child miss school? What did the child do during schooldays that preceeded leaving school and going home? Why did parents decide to let the child come home?

A description of behaviors related to school refusal. How did the child behave in the morning before going to school? On Sunday evening? During times when the child called the parent from school?

A description of the family context. What is a typical school day routine for this family? Do both parents work? What are the before/after school child care arrangements? How long has this routine been in place? How well did the child cope with the routine prior to the phobic reaction?

A description of the school context. What is the nature of the child's school adjustment? How adequate is performance on academic tasks? Are there specific aspects of school that the child found anxiety-provoking? How did the child socialize with classmates? What were the child's friendships like? How many good friends did the child have? What kinds of things did they do together? Had there been recent changes in the child's friendship patterns? How did the child feel about school prior to the phobic reaction?

A description of anxiety incidents from the past. Were there any instances of school refusal in the past? On beginning first grade? After vacations or at the beginning of the school year? What had past school attendance been like? Were there other instances of the child having excessive fears? How were those handled? Were there other relatives who had experiences of excessive or unusual fear in some situations?

A description of any precipitating events. What recent changes had occurred in the family or school situation? Illnesses in the family? Changes in teachers? Was the family undergoing any crises? Alcohol or drug abuse? Family quarrels?

Table 3. Pre- and Post-treatment Responses of Four School Phobic Children to the Louisville Fear Survey

	Total Number of Fears Reported		Number of Severe/ Unusual Fears	
	Pre	Post	Pre	Post
Donna	66	27	46	8
Alice	25	n.a.	11	n.a.
Jeff*	11 30	10	3 11	2
Ryan	56	Not yet complete	7	Not yet complete

*Pre- scores given for both spring, 4th grade and fall, 5th grade.

Table 4. Three School Phobic Children on the Revised Children's Manifest Anxiety Scale.

	Alice		Jeff[a]			Ryan	
	Pre	Post	Pre[1]	Pre[2]	Post	Pre	Post
Total anxiety (T score)	69*	58	57	64*	49	38	case not yet complete
Subscale (Scaled score) physiological	14*	11	10	15*	11	4	
Worry/ Oversensitivity	15*	13*	13*	13*	10	8	
Social Concerns	14*	9	10	11	5	6	
Lie	6	6	6	6	6	11	

[a]Pre-treatment scores are given for both spring, 4th grade (pre 1) and fall, 5th grade (pre 2)

*at or above 1 SD above mean.

Table 5. Pre- and Post-treatment Retrospective Anxiety Ratings for a Typical School Day for Three School Phobic Children. (1 = extremely calm; 7 = extremely upset)

Stage of School Day	Alice		Jeff[b]			Ryan[a]
	Pre	Post	Pre[1]	Pre[2]	Post	Pre
Awakening	1	1	2	2	1	4
Preparation for School	2	1	2	2	1	6
Leaving Home	2.5	1	7	3	1	5
Travel Time	2	1	6	0	1	5
Arriving at School	4	2	7	7	1	4
Morning	7	2	4	3	1	3
Lunch	6	1	1	1	1	1
Recess	6	1	7	6	1	1
Afternoon	6	1	5	1	1	2
Going Home	3	1	7	1	1	1

[a]Post-scores unavailable as case is not yet complete.
[b]Pre-treatment scores are given for both spring, 4th grade (pre 1) and fall, 5th grade (pre 2)

Table 6. Alice's On-site Subjective Anxiety Ratings for a Typical School Day. Daily Ratings are Averaged Across Each Week and Across Several Steps Per TIme Period.

Period	Week 1	Week 2	Week 3	Week 4
Awakening	1	1	1	1
Early morning preparation	1.5	1	1	1
Leaving home	2.5	3	2	1
Travel	2	3	2	1
Arrival at school	4.5	4	2.5	2
Morning	7	3.5	3	2
Lunch	6	2	3	1
Recess	6	2	2	1
Afternoon	6	2	2	1
Going home	3	1	1	1

Table 7. Donna's Daily Steps to School with Associated Subjective Anxiety Ratings.

Day	Last Step Completed	Anxiety Rating
1	Driving past school	4
2	Stopping in school parking lot	4
3	Walking to edge of school porch	6
4	Walking to school entry door	7
5	Going through second entry door and leaving of entry stairs	6
6	Standing in hallway at top	7
7	Sitting in desk in classroom	6
8	Meeting and talking with substitute teacher	5
9	Doing assignment in desk	5
	5 week interval	
10	Meeting with classmates in classroom	6
11	Meeting with classmates in classroom	5
12	Meeting with classmates in classroom	5
13	Waiting with classmates until 25 minutes before class starts	4
14	Waiting with classmates until 20 minutes before class starts	5
15	Waiting with classmates until 15 minutes before class starts	4
16	Waiting with classmates until 10 minutes before class starts	4
17	Waiting with classmates until class starts	4
18	Waiting with classmates for 15 minutes of first class	4
19	Staying through first period with mom waiting	4
20	Staying through second period with mom waiting	4
21	Staying through third period with mom waiting	4
22	Staying until lunch with mom waiting	4
22	Driving through parking lot	6
23	Stayed until lunch with mom waiting	4
24	Staying until lunch with mom leaving for a brief time	4
25	Staying until lunch with mom leaving longer time	4
26	Staying until lunch with mom leaving longer time	4
27,28, & 29	Staying until lunch without mom	4
30, 31	Staying through lunch	4
32	Staying through first class after lunch	4
33	Staying all day	4

Level	Representative example
1. Extremely calm	Family together playing a game or watching tv
2. Very Calm	Talking to the special friend; writing or reading her letters
3. Calm	Family together with Rand
4. Neither calm or upset	Alone and playing with sister
5. Upset	All alone, reading a book or watching tv
6. Very upset	A family celebration day
7. Extremely upset	Last year's birthday

Figure 1: Alice's Anxiety Scale

Anxiety rating	Steps in a typical school day
1	1. Dad wakes Alice up
1	2. Shower, dress, brush teeth
1	3. Go downstairs to eat breakfast
2	4. Say goodbye to Dad
2	5. Wake up sister
2	6. Make bed
3	7. Say goodbye to Mom and sister
2	8. Go to bus stop
2	9. Get on bus and ride to school
4	10. Get out at school
4	11. Sit on steps before class
4	12. Walk toward the classroom
5	13. Stand outside the classroom and see everyone inside
6	15. Enter classroom
7	16. Sit in desk
7	17. Meet and talk with kids
7	18. Stay through first period
7	19. Stay through second period
7	20. Stay through third period
6	21. Stay through fourth period
6	22. Stay through lunch
7	23. Stay through first period after lunch
6	24. Stay through second period after lunch
5	25. Stay through end of the day
3	26. Ride bus home

Figure 2: Alice's schedule of a typical school day with associated retrospective subjective anxiety ratings as given on a first appointment.

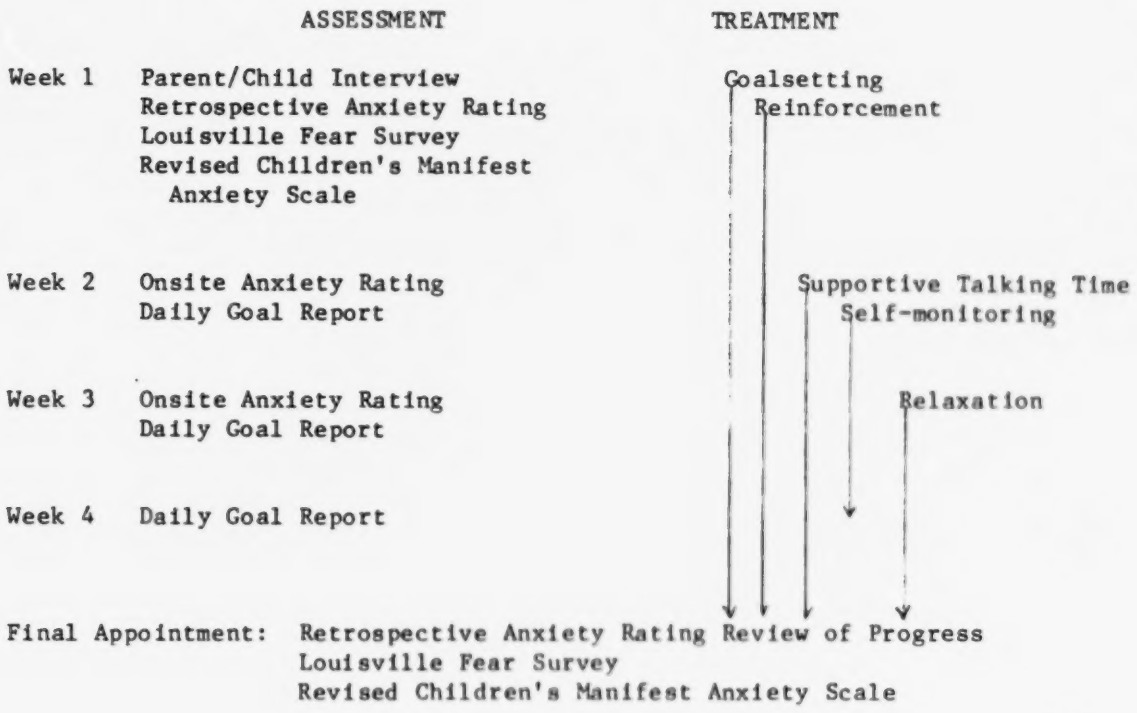

FIGURE 3. Modal Schedule of Treatment and Assessment Procedures.

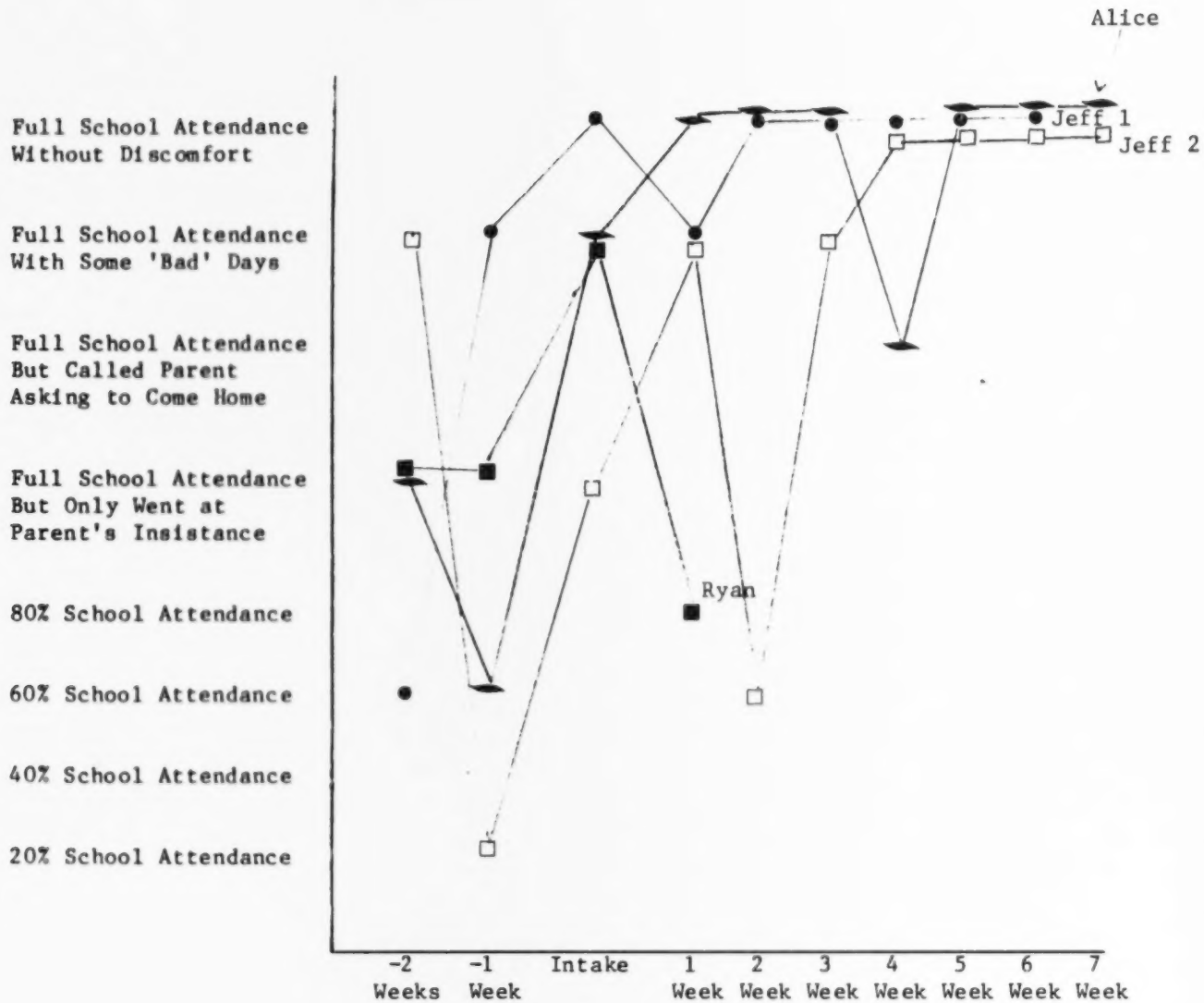

FIGURE 4. Progress of Treatment Over Time for Four School Phobic Cases.

Week of _____

1. Go to school _____ _____ _____ _____ _____

2. Stay in school _____ _____ _____ _____ _____

3. Write down teasing or any times when you were hurt.

_____ _____ _____ _____ _____

4. Practice relaxation tape.

_____ _____ _____ _____ _____

Total for day _____ _____ _____ _____ _____

Weekly total _____

Weekly goal: _____ Weekly reward:_____

Daily goals:

Monday _____
Tuesday _____
Wednesday _____
Thursday _____
Friday _____

Figure 5: Jeff's Weekly Checklist